U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 06 July 2006

In the Matter of
MARTHA JOHNSON, Widow of
WALTER JOHNSON
Claimant
v. Case No. 2004-BLA-00159

BETH ENERGY MINES, INC.
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

APPEARANCES:

Andrew Delph, Esquire
For the Claimant

Natalie Brown, Esquire
For the Employer

DECISION AND ORDER ON MODIFICATION REQUEST
DENYING BENEFITS

This proceeding arises from a claim for benefits under 30 U.S.C. §§ 901-945. In accordance with the Act and regulations issued thereunder, this case was referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Programs for a formal hearing. Benefits under the Act are awardable to persons who are totally disabled within the meaning of the Act due to pneumoconiosis. Benefits are also awardable to the survivors of persons whose death was caused by pneumoconiosis. Pneumoconiosis is a dust disease of the lungs arising from coal mine employment and is commonly known as black lung.

Procedural History

The late miner, Walter Johnson, filed a claim for Federal black lung benefits on or about September 8, 1982 (DX 39, pp. 98-101). On July 28, 2003, the Deputy Commissioner (now known as the District Director) issued an "Award Benefits" (DX 39, pp. 16-18), pursuant to an "Agreement to Pay Benefits" entered into by Beth-Elkhorn Corp. (DX 39, pp. 19-21).

Accordingly, the miner was receiving Federal black lung benefits at the time of his death. The only pending matter is the survivor's claim, as discussed herein.

On September 6, 2000, Walter Johnson passed away (DX 8). On September 26, 2000, the Claimant, Martha Johnson, filed the current application for black lung benefits under the Act, as his surviving spouse (DX 1). This claim was awarded by the District Director in a Proposed Decision and Order, dated May 1, 2001 (DX 35). Following Employer's timely request for a formal hearing (DX 36), and further development of the evidence, Administrative Law Judge Stephen L. Purcell issued a Decision and Order-Denying Benefits, dated May 8, 2003 (DX 78). On July 14, 2003, Claimant submitted a "Motion to File Appeal Out of Time" (DX 79). Following Employer's response thereto (DX 80), the Benefits Review Board issued an Order, dated July 29, 2003, in which it construed the Claimant's motion as a Notice of Appeal, but dismissed the appeal as untimely filed (DX 81).

On or about January 8, 2004, Claimant filed a timely request for modification together with additional medical evidence (DX 84). On June 15, 2004, the District Director issued a Proposed Decision and Order Granting Request for Modification (DX 91). Following Employer's timely request for a formal hearing (DX 92), this matter was returned to the Office of Administrative Law Judges for *de novo* adjudication (DX 98-99).

A hearing was held on November 1, 2005 in Hazard, Kentucky. At that time, all parties were afforded full opportunity to present evidence and argument as provided in the Act and regulations issued. Furthermore, the record was held open for the submission of post-hearing evidence and briefs. The transcript of the deposition of Dr. Jarboe, dated October 20, 2005, which was filed under cover letter, dated November 9, 2005, has been marked and received as Employer's Exhibit 5 (EX 5). In summary, the record consists of the hearing transcript, Director's exhibits 1 through 99 (DX 1-99), and Employer's Exhibits 1 through 5 (EX 1-5).

Findings of Fact and Conclusions of Law

Applicable Law

This claim was filed after March 31, 1980, the effective date of Part 718 of the regulations, but prior to January 19, 2001 (*i.e.,* the effective date of the current regulations). Although some of the current regulations apply to both pending and newly filed cases, the provisions which do not apply retroactively include 20 C.F.R. §725.310 and §725.414. *See* 20 C.F.R. §725.2. Accordingly, the new modification provisions and the new evidentiary limitations on the development of evidence do not apply to this claim, which was initially filed on September 26, 2000 (DX 1; TR 5).

Stipulations

The Employer stipulated, and I find, that: Mr. Johnson was a miner, who had worked in that capacity after December 31, 1969; the miner worked *at least* 19 years in or around one or more coal mines.[1] Claimant is an eligible survivor of the miner; Beth Energy Mines, Inc. is the properly designated responsible operator; Employer has secured the payment of benefits (DX 98; TR 7-9, 13).

[1]The miner had claimed "about 35" years of work in or around the coal mines (DX 39, p. 98). Judge Pucell had found 31 years of coal mine employment (DX 78, pp. 19-20). For the purpose of rendering this decision, I find that any discrepancy in Mr. Johnson's coal mine employment in excess of the 19 years stipulated by Employer is inconsequential for the purpose of rendering a decision herein.

Issues

In a survivor's claim, Claimant must prove that: (1) the miner suffered from pneumoconiosis; (2) the pneumoconiosis arose out of coal mine employment; and, (3) the miner's death was due to pneumoconiosis within the meaning of the Act and applicable regulations.[2] The failure to prove any requisite element precludes a finding of entitlement. ***Anderson v. Valley Camp of Utah, Inc.,*** 12 B.L.R. 1-111 (1989); ***Perry v. Director, OWCP,*** 9 B.L.R. 1-1 (1986) (*en banc*). Since this is a modification request, Claimant must also establish a mistake in a determination of fact, pursuant to 20 C.F.R. §725.310.[3] The Employer contests all of the above-stated issues.[4]

Burden of Proof

The concept of "burden of proof," as used in this setting and under the Administrative Procedure Act ("APA"),[5] is as follows: "Except as otherwise provided by statute, the proponent of a rule or order has the burden of proof." "Burden of proof" means burden of persuasion, not merely burden of production. 5 U.S.C. § 556(d).[6] The drafters of the APA used the term "burden of proof" to mean the burden of persuasion. *Director, OWCP, Department of Labor v. Greenwich Collieries* [*Ondecko*], 512 U.S. 267, 18 B.L.R. 2A-1 (1994).[7]

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[2] Although not specifically raised before the undersigned, I find that the Employer is not collaterally estopped from litigating the "pneumoconiosis" and "causal relationship" issues. In so finding, I note that the miner's claim was not fully litigated. Furthermore, the parties herein are not identical with those involved in the miner's case. In addition, Employer's willingness to pay Federal black lung benefits in the miner's case may have been related to the award of benefits by the Commonwealth of Kentucky, since such benefits are subject to offset (*See* DX 39, pp. 80-81).

[3] Since this is a survivor's claim, Claimant cannot establish a "change in conditions" under §725.310.

[4] At the formal hearing, Employer continued to contest the "timeliness" issue (DX 99; TR 6-7). However, in its post-hearing brief, Employer conceded that the widow claim was timely filed (Employer's Brief, p. 2). Moreover, the regulations specify that there is "no time limit on the filing of a claim by the survivor of a miner." 20 C.F.R. §725.308(a).

[5] 33 U.S.C. § 919(d) ("[N]otwithstanding any other provisions of this chapter, any hearing held under this chapter shall be conducted in accordance with [the APA]"); 5 U.S.C. § 554(c)(2). Longshore and Harbor Workers' Compensation Act ("LHWCA"), 33 U.S.C. § 901-950, is incorporated by reference into Part C of the Black Lung Act pursuant to 30 U.S.C. § 932(a).

[6] The Tenth and Eleventh Circuits held that the burden of persuasion is greater than the burden of production, ***Alabama By-Products Corp. v. Killingsworth***, 733 F.2d 1511, 6 B.L.R. 2-59 (11th Cir. 1984); ***Kaiser Steel Corp. v. Director, OWCP*** [***Sainz***], 748 F.2d 1426, 7 B.L.R. 2-84 (10th Cir. 1984). These cases arose in the context where an interim presumption was triggered, and the burden of proof shifted from a claimant to an employer/carrier.

[7] Also known as the risk of nonpersuasion, *See* 9 J. Wigmore, **Evidence** § 2486 (J. Chadbourn rev. 1981).

Lay Evidence

The miner, Walter Johnson, was born on January 23, 1925. He married Martha Johnson (nee Kelly) on January 10, 1947. They remained married until the miner's death on September 6, 2000, at age 75. Claimant has not remarried since her husband's death (DX 7, 8; TR 12).

Claimant testified that she believes her husband had black lung, citing a finding of second stage black lung by Dr. Nash. She also stated that her husband couldn't work in the truck mines because he was shot in the hip, and noted that Mr. Peterson had seen Dr. Nash following a heart attack (TR 13-14). Claimant acknowledged that she was not educated to be a nurse, but stated that she took care of her husband (TR 16).

Findings of Fact

For the reasons set forth herein, I find that Claimant has not established the presence of pneumoconiosis, nor has he established that the disease caused, contributed to, or hastened the miner's death. These are the same grounds upon which Judge Purcell had previously denied this claim (DX 78, pp. 34, 36). Therefore, Claimant has not established grounds for modification under §725.310. Accordingly, Claimant is not entitled to benefits under the Act.

New Medical Evidence

The record contains the following new medical evidence, which was submitted in conjunction with Claimant's request for modification of Judge Purcell's Decision and Order-Denying Benefits, dated May 8, 2003 (DX 78).

Chest X-rays

Dr. Spitz, a B-reader and Board-certified radiologist, reread the chest x-ray, dated May 9, 1994, as follows: "IMPRESSION: 1. No evidence of coal worker's pneumoconiosis. 2. Emphysema." (DX 90).[8]

Physicians' Opinions

The medical opinion evidence in the record includes the recent reports and/or depositions of Drs. Perper (DX 84), Jarboe (DX 86; EX 5), Dahhan (DX 90), Caffrey (EX 1, 4), Castle (EX 2), and Repsher (EX 3).

Dr. Joshua A. Perper is Board-certified in Anatomical & Surgical Pathology, and, Forensic Pathology. Furthermore, Dr. Perper has a law degree and is a medico-legal consultant (DX 84). Dr. Perper issued a report, dated December 23, 2003, in which he reviewed the available evidence, and attached an Appendix, entitled "Coal Worker's pneumoconiosis and associated centri-lobuar emphysema," which cites medical literature (DX 84). Dr. Perper questioned the opinions of several, well-qualified pulmonary specialists, who had found that the miner did not suffer from pneumoconiosis and/or that the miner's death was unrelated to pneumoconiosis. Dr. Perper presented and answered various medico-legal questions. Dr. Perper found that the miner had coal worker's pneumoconiosis, citing the following: a coal mine employment history of 35 years of which 31 was spent underground, and medical literature which indicates that various percentages of working bituminous and anthracite miners contract pneumoconiosis; clinical symptoms of productive coughing and occasional wheezing; abnormal

[8] This additional negative x-ray interpretation merely buttresses the finding of Judge Purcell (*See* DX 78, pp. 4-9, 21-22).

clinical test results; and, a number of radiologists who found "significant simple coal workers' pneumoconiosis or pulmonary nodularites." (DX 84, pp. 22-24). Furthermore, Dr. Perper found that pneumoconiosis substantially contributed and/or hastened the miner's death. In so finding, Dr. Perper stated:

> Based on Mr. Johnson's long-standing occupational history of coal mining and exposure to coal mine dust, his respiratory symptomatology, the objective evidence of primarily obstructive lung disease and hypoxemia, the overwhelming diagnoses of coal workers' pneumoconiosis both radiologically and clinically, it is my professional opinion within a reasonable degree of medical certainty that there is competent medical evidence that coal workers' pneumoconiosis was a significant contributory cause of death of Mr. Johnson (along with the primary cause of death: the arteriosclerotic cardio-vascular) and a hastening factor of his death, both directly and indirectly through:
>
> - Direct replacement of normal lung tissue by pneumoconotic lesions and associated centrilobular chronic emphysema and resulting hypoxemia, which was also demonstrated clinically
> - The mechanism of death contributed by the presence of coal workers pneumoconiosis was through the following pathways:
>   a. Direct pulmonary insufficiency due to replacement of normally breathing lung by non-breathing pneumoconiotic tissues associated with centrilobular emphysema, and resulting hypoxemia.
>   b. Through hypoxemia precipitating/aggravating a cardiac arrhythmia in an individual with heart disease….(medical citations omitted).

(DX 84, pp. 26, 27). In conclusion, Dr. Perper stated:

> 1. Mr. Johnson had evidence of significant and substantial coal workers' pneumoconiosis, causally associated with chronic obstructive pulmonary disease and hypoxemia.
> 2. Mr. Johnson's coal worker's pneumoconiosis was the result of more than thirty-five (35) years of occupational exposure as a coal miner to coal dust containing silica, a more than sufficient exposure period necessary for developing coal workers' pneumoconiosis.
> 3. Coal workers' pneumoconiosis and the causally associated chronic obstructive pulmonary disease (COPD), was a substantially contributory cause of Mr. Johnson's death both directly and indirectly through pulmonary insufficiency and through hypoxemia triggering or aggravating an arrhythmia, on the background of heart disease.

(DX 84, p. 32).

Dr. Thomas M. Jarboe is a B-reader and Board-certified pulmonary specialist, who had previously issued medical reports, dated April 23, 2001 (DX 34) and February 26, 2002 (DX 51), and had also testified at deposition on May 14, 2002 (DX 64) and September 23, 2002 (DX 72). Moreover, Dr. Jarboe had treated Mr. Johnson, when the miner was hospitalized at St. Joseph's Hospital, in September 1999 (EX 5, p. 13).

In a supplemental report, dated February 22, 2004, Dr. Jarboe addressed and expressly disagreed with Dr. Perper's opinion (DX 86). While agreeing that a 35-year coal mine employment history is sufficient to develop pneumoconiosis, Dr. Jarboe stated that it depends on the susceptibility of the individual miner. Furthermore, Dr. Jarboe stated that the statistical data in the medical literature cited by Dr. Perper regarding the increased incidence of pneumoconiosis

based on duration of coal mine work is outdated. Moreover, Dr. Jarboe stated that the symptoms cited by Dr. Perper are entirely nonspecific. Furthermore, Dr. Jarboe noted that the abnormal pulmonary function studies and arterial blood gases, including reversible airways disease treated with bronchodilators and steroids, as well as hyperresponsiveness, are not consistent with pneumoconiosis, but rather cigarette smoking and asthma. In addition, Dr. Jarboe rejected Dr. Perper's suggestion that the x-ray evidence revealed significant simple pneumoconiosis or pulmonary nodularities. To the contrary, Dr. Jarboe stated that nearly all of the x-rays performed in the course of the miner's medical care showed severe COPD with bleb formation, not a pattern suggestive of coal worker's pneumoconiosis. Similarly, the CT scan evidence confirmed a finding of severe COPD with bullae, but did not suggest a diagnosis of pneumoconiosis. In addition, Dr. Jarboe questioned Dr. Perper's suggestion that asthma occurring at age 61 is highly unusually, noting that, as a practicing pulmonologist, he has seen the development of asthma at all ages. Furthermore, Dr. Jarboe challenged Dr. Perper's statement that normal lung tissue was replaced by pneumoconiotic lesions and associated centrilobular emphysema, noting that this was not demonstrated on the chest x-rays or CT scans. Dr. Jarboe stated that this further undermines Dr. Perper's opinion regarding the death due to pneumoconiosis issue. In summary, Dr. Jarboe stated, in pertinent part:

> As stated in my original report, it is my opinion within a reasonable degree of medical certainty and/or probability that Mr. Walter Johnson had severe pulmonary emphysema with severe airflow obstruction which was caused by a 50 pack year history of smoking cigarettes. It is my reasoned opinion that coal worker's pneumoconiosis did not cause, contribute to or in any way hasten the death of Mr. Walter. It is likely that his death was caused by coronary artery disease with associated arrhythmias. While it is true that hypoxemia may have contributed to these arrhythmias, it is my reasoned opinion that such hypoxemia was the cause of his chronic obstructive airways disease which I turn was caused by cigarette smoking.

(DX 86). In his deposition testimony on October 20, 2005, Dr. Jarboe reiterated the above-stated opinion (EX 5). Furthermore, Dr. Jarboe specified that the miner did not have (medical or legal) pneumoconiosis (EX 5, pp. 21-24). Moreover, Dr. Jarboe expressly stated that, even if Mr. Johnson had had simple pneumoconiosis, it would not change his opinion regarding the death causation issue (EX 5, p. 27), while noting that the pneumoconiosis, if found, did not progress to the point where it was replacing normal lung tissue with lesions (EX 5, p. 30). In summary, Dr. Jarboe attributed the miner's death to "some type of cardiac arrhythmia, probably ventricular tachycardia, which in turn evolved into ventricular fibrillation." The latter was "caused by underlying coronary artery and congestive heart failure, plus it is possible that his lung disease contributed as well." However, if the lung disease contributed, it was due to smoking with resultant emphysema. Accordingly, Dr. Jarboe opined that coal worker's pneumoconiosis and/or coal dust exposure did not cause, contribute, or hasten the miner's death (EX 5, p. 31).

Dr. Abdul Dahhan is a B-reader and Board-certified pulmonary specialist, who had previously issued medical reports, dated April 9, 2001 (DX 33) and February 12, 2002 (DX 49), and had also testified at deposition on May 13, 2002 (DX 64).

After reviewing Dr. Perper's report, Dr. Dahhan issued a supplemental report, dated February 19, 2004, in which he challenged Dr. Perper's opinion (DX 90). While acknowledging that 35 years is a sufficient period of exposure to cause the development of coal worker's pneumoconiosis, Dr. Dahhan opined that Mr. Johnson was not a susceptible host. Secondly, Dr. Dahhan stated that Dr. Perper's reliance upon Dr. Attfield's study is misplaced, because the

miner would only have lost between 200-300 cc of his FEV1 due to coal dust inhalation. Dr. Dahhan opined that such a reduction is highly insufficient to cause significant respiratory impairment and would definitely not cause the degree of pulmonary disability suffered by the miner. Furthermore, in response to Dr. Perper's contention that coal dust exposure can cause centriacinar emphysema in coal miners, Dr. Dahhan cited medical literature under the heading "Simple Coal Workers' Pneumoconiosis," which stated that the "condition is best described in a coal miner whose lungs have accumulation of large amounts of coal dust around the respiratory bronchials and accompanied primarily [by] underlying distension as a contrast to centrilobular emphysema, in which there is a destruction of respiratory tissue even in mild samples." However, Dr. Dahhan stated, in Mr. Johnson's case, "there is a disagreement regarding the presence of simple coal workers' pneumoconiosis." In addition, Dr. Dahhan questioned the bases of Dr. Perper's opinion to rule out asthma, noting that it is contrary to the medical literature, and stating that asthma can be a disease of the elderly which had been asymptomatic. In conclusion, Dr. Dahhan stated:

> Based on the above, I disagree with Dr. Perper's conclusion that this patient's chronic obstructive lung disease was a result of his coal dust exposure and that coal workers' pneumoconiosis contributed, brought on or hastened his final demise.

(DX 90).

Dr. P. Raphael Caffrey, who is Board-certified in Anatomical and Clinical Pathology, issued a report, dated September 20, 2005, in which he reviewed and analyzed the available evidence (EX 1). Dr. Caffrey reported an apparent coal mine employment history of approximately 31-35 years, mostly underground, including work for Employer from 1966 to 1982. He noted that some hospital records had reported that Mr. Johnson smoked one pack per day for almost 61 years ending in 1987, and/or, one pack for 50 years ending in 1987. Dr. Caffrey also answered various questions which were posed by Employer's counsel, including those relevant to the "pneumoconiosis" and "death causation" issues. Dr. Caffrey stated, in pertinent part:

> ***Is there sufficient objective evidence to justify a diagnosis of CWP?***
>
> ANSWER: I do not believe the objective evidence available definitely proves that Mr. Johnson had CWP. I say that for the following reason:
>
> a. Numerous chest x-rays interpreted on Walter Johnson by physicians both employed by the coal company and by Mr. Johnson were read both as positive and negative. In my opinion the objective chest x-ray interpretations were those from Pikesville Methodist Hospital of which there were 17 interpretations from 1980 through September 2000 by Board-certified radiologists who were B-readers and none of those interpretations made a diagnosis of CWP. There was one CT scan interpretation in November 1999 and this CT scan did not have interpretations of CWP. There were two chest x-ray interpretations from Saint Joseph Hospital in October 1999 and one CT scan interpretation and these were not read as positive for CWP. I must objectively state that because the x-rays were not interpreted as showing evidence of CWP, in my objective expert opinion that does not mean Mr. Johnson did not have CWP. What it means in my opinion is that pathologically it certainly is possible Mr. Johnson may have had <u>simple</u> CWP and it would be a mild degree of simple CWP since these chest x-rays were not reads as positive for CWP at the two hospitals, one of which was Pikesville Methodist Hospital….

In your opinion within a reasonable degree of medical certainty, did CWP cause, contribute to or in any way hasten this man's death?

ANSWER: It is definitely my objective opinion that even if we assume that Mr. Johnson had simple CWP it would definitely have been of a mild degree for the reasons I noted above, and simple CWP did not incapacitate the patient and did not cause, contribute to or hasten his death.

(EX 1, pp. 3-5). Furthermore, Dr. Caffrey addressed Dr. Perper's opinion, as set forth in the latter's report, dated December 23, 2003. Dr. Caffrey stated, in pertinent part: "Individuals with 31 years of coal mining experience underground may have a) absolutely no simple CWP or b) they may in a susceptible individual have mild simple CWP which could be the case of Mr. Johnson, or c) they could have severe simple CWP which is definitely not the case of Mr. Johnson." In so finding, Dr. Caffrey, again, cited the objective x-ray and CT scan evidence, by physicians not retained by Claimant or Employer, who did not diagnose CWP. In addition, Dr. Caffrey flatly disagreed with Dr. Perper's finding of "significant and substantial CWP," stating that it was unsupported by the evidence; and, that the miner's significant COPD was related to his extensive cigarette smoking history, as found by the pulmonologists. Moreover, Dr. Caffrey challenged Dr. Perper's statement that CWP was a substantial contributory cause of Mr. Johnson's death, both directly and indirectly, stating that Dr. Perper failed to admit the significance of the miner's extensive heart disease, including coronary artery disease, arteriosclerotic heart disease, pacemaker placement, prior myocardial infarction, and congestive heart failure, all unrelated to coal mine employment. In addition, Dr. Caffrey noted that the statistical data cited by Dr. Perper regarding the prevalence of CWP among bituminous miners with 30 to 39 years of exposure indicates that only 18% contract the disease. Moreover, Dr. Caffrey stated that Dr. Perper had not considered relevant evidence regarding the finding of sputum containing eosinophilla, which is an asthma indicator. Dr. Caffrey also questioned Dr. Perper's citation of medical literature involving non-smokers, in view of the miner's extensive cigarette smoking history (EX 1, pp. 6-8). Finally, Dr. Caffrey stated:

> In conclusion it is my objective opinion that it is possible that Mr. Johnson could have had simple CWP, but if he did it would have been of a mild degree for the reasons I previously documented and it would not have caused any discernible or significant pulmonary problems by itself. Mr. Johnson had for years significant pulmonary and cardiac problems and his pulmonary problems of emphysema were due to his years of cigarette smoking, and I am sure this [sic] years of smoking cigarettes played a significant role in his developing coronary artery disease and the problems arising from that having had a myocardial infarction, requiring a pacemaker and having documented multiple cardiac arrhythmic problems. The patient was said to have collapsed at home and it is certainly quite possible the patient had a fatal arrhythmia secondary to possibly another myocardial infarction. It is unfortunate that an autopsy was not performed.

(EX 1, p. 8). In his deposition testimony on October 18, 2005, Dr. Caffrey reiterated the above-stated opinion, stating that the objective evidence does not establish the existence of (medical or legal) coal worker's pneumoconiosis, but even assuming its presence, it did not cause, contribute, or hasten the miner's death (EX 4, pp. 18-25).

Dr. James R. Castle is a B-reader and Board-certified pulmonary specialist, who had previously issued a reviewing medical report, dated February 26, 2002 (DX 50) and had also testified twice by deposition on May 13, 2002 (DX 64) and October 4, 2002 (DX 73), respectively.

In a supplemental report, dated September 29, 2005 (EX 2), Dr. Castle reviewed the available evidence, including the recent report by Dr. Perper. Dr. Castle questioned the conclusions of Dr. Perper on various bases. Dr. Castle stated that the miner had sufficient exposure to develop pneumoconiosis, *"if he were a susceptible host*," which varies from individual to individual. He noted that the studies cited by Dr. Perper regarding the prevalence of pneumoconiosis were performed in the 1950's and 1960's, prior to the institution of dust limits. Dr. Castle also cited the miner's extensive cigarette smoking history and multiple heart problems, and noted that the x-ray and CT scan evidence did not reveal radiographic manifestations of coal workers' pneumoconiosis. Dr. Castle also rejected Dr. Perper's finding of no asthma, noting that the evidence revealed significant bronchospastic disease responsive to steroid therapy. Dr. Castle also noted that Dr. Perper's had improperly relied on nonspecific symptoms to diagnose pneumoconiosis and utilize such information to relate the miner's impairment and death to the disease. Moreover, Dr. Castle stated that the evidence does not support Dr. Perper's assertion that normal lung tissue had been replaced by pneumoconiotic lesions resulting in emphysema and hypoxema. Furthermore, Dr. Castle cited the miner's very significant cardiac disease, unrelated to coal worker's pneumoconiosis. In conclusion, Dr. Castle stated:

> Therefore, in summary, it remains my opinion with a reasonable degree of medical certainty that Mr. Walter Johnson did not suffer from coalworkers' pneumoconiosis. It is my opinion that Mr. Walter Johnson did have a disabling degree of respiratory impairment which occurred as a result of his long and extensive tobacco smoking habit which resulted in the development of severe bullous emphysema. Some of his airway obstruction was contributed to by asthmatic bronchitis. It is my opinion that he was not permanently and totally disabled as a result of coalworkers' pneumoconiosis or as a result of coal mine dust induced lung disease. It is my opinion with a reasonable degree of medical certainty that his death was not caused by, contributed to, or hastened in any way by coalworkers' pneumoconiosis or coal mine dust exposure. His death was due to a cardiac arrhythmia related to his known cardiac disease and contributed to by tobacco smoke induced bullous emphysema.

(EX 2, p. 10).

Dr. Lawrence H. Repsher, a B-reader and Board-certified pulmonary specialist, issued a report, dated September 28, 2005, in which he reviewed and analyzed the available evidence (EX 3). Dr. Repsher reported a coal mine employment history of about 35 years ending in 1982 following a myocardial infarction; a 50-year cigarette smoking history of one-half to one pack daily ending in 1987; and, the miner's family history, which indicated that both his parents had heart disease. Dr. Repsher stated that the miner's past medical history included: "Myocardial infarctions in 1981 and 1989. Bilateral bullous emphysema secondary to cigarette smoking, with a large left bulla. Hypercholesterolemia, hypertension, colonic diverticulosis, asthmatic bronchitis, and intermittent angina pectoris and congestive heart failure. Dr. Repsher summarized the relevant evidence, including the miner's multiple hospitalizations, chest x-ray and CT scan evidence, pulmonary function tests and arterial blood gases. Dr. Repsher also set forth the pulmonary consultations by Drs. Jarboe and Dineen, who treated the miner, in September and October 1999. Furthermore, Dr. Repsher summarized the medical opinions of numerous other physicians, as stated in various reports and depositions. Dr. Repsher criticized Dr. Perper's opinion on multiple grounds, and found it to be "seriously flawed, misleading, and

inaccurate." On the other hand, Dr. Repsher expressly agreed with the evaluations by Drs. Jarboe and Dahhan of Dr. Perper's report (EX 3, pp. 5-7).
In summary, Dr. Repsher provided answers to questions posed by Employer's counsel, as follows:

1. Mr. Walter had insufficient objective evidence to justify a diagnosis of coal workers pneumoconiosis prior to his death.
2. He had a severe obstructive ventilatory impairment, which was partially reversible prior to his death. Neither the asthma nor the bullous emphysema were due to the inhalation of coal mine dust. His bullous emphysema was due to his prolonged and heavy cigarette smoking history.
3. From a respiratory or pulmonary standpoint, Mr. Johnson suffered from a reduced capacity to perform his coal mine employment prior to his death. The inhalation of coal mine dust did not materially worsen his totally disabling respiratory or pulmonary impairment, caused by cigarette smoking which is unrelated to coal mine employment.
4. Mr. Johnson did not have coal workers pneumoconiosis and, therefore, there was no significant effect on [sic] the inhalation of coal dust on his course prior to his death.
5. In my opinion, given with a reasonable degree of medical certainty, coal worker's pneumoconiosis did not cause, contribute to, or in any [sic] hasten Mr. Walter Johnson's death.
6. Even if Mr. Johnson were found to have coal workers pneumoconiosis, my opinion regarding the cause of death or the role that coal dust exposure played in Mr. Johnson's death would not change. Mr. Johnson's death was due to cardiac arrhythmias and congestive heart failure, related to his underlying coronary artery disease.

(EX 3, p. 10).

Modification Under 20 C.F.R. §725.310

As stated above, this case involves a modification request. Therefore, the threshold issue is whether a change in conditions or mistake in a determination of fact has been established, as provided in §725.310. However, as previously noted, a "change in conditions" cannot be established, since this is a survivor's claim. The Board has held that, in any case involving a modification request, the fact-finder should review the claim for a "mistake in a determination of fact," regardless of whether it is specifically alleged. *Kingery v. Hunt Branch Coal Co.*, 19 BLR 1-6 (1994). Accordingly, I must conduct a *de novo* review of all the evidence, both old and new.

In his Decision and Order-Denying Benefits, dated May 8, 2003 (DX 78), Judge Purcell considered the, then, available medical evidence, including the following: chest x-rays covering the period from July 30, 1981 through September 7, 2000; pulmonary function studies from July 21, 1982 through November 6, 1995; arterial blood gas tests dated February 3, 1982 through September 6, 2000; various treatment notes; and, the medical opinions of Drs. Nash, Clarke, Williams, Johnson, Broudy, Dahhan, Jarboe, Castle, Dineen, Wiot, and Spitz. Based upon his detailed analysis, Judge Purcell stated that the evidence does not establish the existence of pneumoconiosis and/or death due to pneumoconiosis within the meaning of the Act and regulations (DX 78).

Based upon my own independent analysis of the medical evidence which was previously considered by Judge Purcell, I also find that the evidence did not establish the presence of pneumoconiosis and/or death due to the disease. In making this determination, I find that the preponderance of the more probative x-ray evidence, including the significantly more recent interpretations by well-qualified B-readers and/or Board-certified radiologists, is negative for pneumoconiosis under the classification requirements set forth in §718.102(b). Furthermore, I find that the clear preponderance of the medical opinion evidence is negative for (clinical and legal) pneumoconiosis, in view of the negative CT scan interpretations by dual-qualified B-readers and Board-certified radiologists (*i.e.,* Drs. Wiot and Spitz), and the well-reasoned medical opinions of several Board-certified pulmonary specialists, such as Drs. Broudy, Dahhan, Jarboe, Castle, and Dineen, which far outweigh the contrary opinions by physicians who either based their opinions on less extensive medical data, or lacked the pulmonary expertise of the above-named physicians. Therefore, Claimant did not establish pneumoconiosis under §718.202(a)(1)-(4).

Rather than establish a "mistake in a determination of fact," the new evidence simply buttresses the prior findings. As stated above, the only additional x-ray reading in evidence was made by Dr. Spitz, a B-reader and Board-certified radiologist, who found no evidence of pneumoconiosis (DX 90). Of the new medical opinion evidence, Dr. Perper's report constitutes the only opinion which, if credited, would establish the presence of pneumoconiosis and death due to the disease (DX 84). Although Dr. Perper is a well-credentialed, Board-certified pathologist, the pulmonary experts all disagree with his opinion, and challenge the underlying bases for Dr. Perper's conclusions. Moreover, Dr. Perper's opinion is not based upon pathological evidence. In view of the foregoing, I accord his opinion less weight. Dr. Caffrey's opinion is also given less weight, because he is a Board-certified pathologist, who did not rely upon biopsy or autopsy evidence. Furthermore, I note that, although Dr. Caffrey clearly stated that the miner's death was unrelated to pneumoconiosis, his opinion is somewhat equivocal regarding the possible of presence of pneumoconiosis (EX 1, 4). I accord greater weight to the recent, well-reasoned and well-documented medical reports and/or depositions of Drs. Jarboe (DX 86; EX 5), Dahhan (DX 90), Castle (EX 2), and Repsher (EX 3), who are all Board-certified pulmonary specialists. Furthermore, I note that Dr. Jarboe had treated Mr. Johnson prior to the miner's death. In view of the foregoing, I find that the post-modification request evidence does not establish the presence of pneumoconiosis and/or death due to the disease.

Since "pneumoconiosis" and "causation" are the elements upon which Judge Purcell denied the claim, Claimant's continued failure to establish these element means that he has failed to establish grounds for modification under §725.310.

Conclusion

Having made a *de novo* review of all the relevant evidence, both old and new, I find no grounds for modification under §725.310. To the contrary, the post-modification evidence merely confirms and buttresses the prior findings that the miner did not have pneumoconiosis and that pneumoconiosis did not cause, contribute to, or hasten the miner's death. Accordingly, Claimant is not eligible for benefits under the Act and regulations.

Attorney Fees

The award of attorney's fees under the Act is permitted only in cases in which Claimant is found to be entitled to benefits. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to Claimant for services rendered him in pursuit of this claim.

ORDER

It is ordered that the claim of Martha Johnson, surviving spouse of Walter Johnson, for benefits under the Black Lung Benefits Act is hereby **DENIED.**

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DANIEL F. SOLOMON
Administrative Law Judge

Washington, D.C.

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with this Decision and Order you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which this Decision and Order is filed with the district director's office. *See* 20 C.F.R. §§725.458 and 725.459. The address of the Board is: ***Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, D.C. 20013-7601.*** Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. §802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor for Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Avenue, N.W., Room N-2117, Washington, D.C. 20210. *See* 20 C.F.R. §725.481.

If an appeal is not timely filed with the Board, this Decision and Order will become the final order of the Secretary of Labor pursuant to 20 C.F.R. §725.479(a).